



# **West Virginia Health Home Provider Qualifications and Standards for Behavioral Health Patient Populations**

## **Bipolar Disorder**

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**with Specific Attention for Risk of Hepatitis B and/or C**

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## Introduction to the WV Health Homes Initiative

### 1. Background Information

As part of the Affordable Care Act of 2010, came the option for States to establish Health Homes. By design, the Health Home is to be a comprehensive system of care coordination for Medicaid recipients with chronic conditions. Health Home providers will coordinate all primary, acute, behavioral health and long-term services and supports to treat the “whole person” across his/her lifespan. Since the focus is on the whole person, all of the health care providers a person sees are part of his/her treatment team. Health Homes have proven to increase the individual’s health while reducing medical costs.

#### Health Home Required Functions

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services.
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
- Coordinate and provide access to mental health and substance abuse services.
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings.
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
- Coordinate and provide access to long-term care supports and services.
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate.
- Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Access additional information on the WV Bureau for Medical Services site [DHHR.WV.GOV/BMS/Pages/WVHH.aspx](http://DHHR.WV.GOV/BMS/Pages/WVHH.aspx) or the Centers for Medicaid and Medicare at [medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html](http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html).

#### 1.1. West Virginia’s Health Home Target Population

The Health Homes Initiative in West Virginia is currently underway. The first Health Home focuses on individuals with a Bipolar Disorder diagnosis infected with or at risk of Hepatitis B and/or Hepatitis C from the following counties Cabell, Kanawha, Putnam, Mercer, Raleigh, and Wayne.

The program will initially target members who have a diagnosis of a Bipolar Disorder identified on Medicaid Claims within the previous two years billing data. The qualifying diagnoses are (ICD 9/ DSM-IV- TR):

296.00	296.06	296.45	296.54	296.63
296.01	296.40	296.46	296.55	296.64
296.02	296.41	296.50	296.56	296.65
296.03	296.42	296.51	296.60	296.66
296.04	296.43	296.52	296.61	296.70
296.05	296.44	296.53	296.62	296.80
				296.89

## 1.2. Medicaid Recipient Enrollment Process

Eligible Medicaid recipients will initially be auto-enrolled by BMS with the option to opt out. Hereinafter these Medicaid recipients will be considered “Enrollees.” The enrollee’s Medicaid card will be flagged in the state’s Medicaid Management Information System (MMIS).

BMS will mail a notice advising the enrollees with a diagnosis of bipolar about the program. Enrollees in the appropriate geographic areas will be advised that they can make their choice of provider.

- The notice will describe the function of the Health Home, the services provided and the individual’s right to select an alternative Health Home.
- Enrollees will be advised that there are no consequences for opting out of services.
- The enrollee will have the option to choose an alternative Health Home.
- Members meeting the target population criteria may also be referred to a health home on an ongoing basis once the program is implemented. The health home in receipt of the member’s referral is responsible for submitting a service request to APS Healthcare for authorization
  - Enrollee request
  - Hospitals Emergency Departments (ED) or Inpatient Care Facilities
  - Referral from Medical and Behavioral Health Providers

## 1.3. Health Home Role

The Health Home provider is the central point for coordinating patient-centered care for enrollees. Health Homes will provide and/or coordinate medical, mental and required outreach services.

**1.3.1.** Health Homes will provide care coordination with projected improvement of patient outcomes by:

**1.3.1.1.** Engaging the services of primary care medical and behavioral health providers, and other medical specialists through:

- 1.3.1.1.1. Providers directly managed by the Health Home or
- 1.3.1.1.2. Formal agreements with appropriate service providers
- 1.3.1.1.3. Risk assessment and testing to confirm Hepatitis B and/or Hepatitis C status

**1.3.1.2.** Health Home providers are accountable for reducing health care costs by:

- 1.3.1.2.1. Preventing unnecessary hospital admissions and /or emergency room visits
- 1.3.1.2.2. Reducing unnecessary readmissions
- 1.3.1.2.3. Providing crisis intervention at appropriate times
- 1.3.1.2.4. Assuring timely medication reconciliation
- 1.3.1.2.5. Health Homes providers will obtain and provide timely post discharge follow up

- 1.3.1.3. Other Health Home responsibilities include:
  - 1.3.1.3.1. Agreeing to provide services for all potentially eligible Health Home enrollees referred to them by BMS
  - 1.3.1.3.2. Communicating medical status and treatment options to the enrollee
  - 1.3.1.3.3. Following all current and future State and Federally mandated privacy and confidentiality laws,
  - 1.3.1.3.4. This includes following guidelines including HIPAA and Affordable Care Act guidelines of 2010
  - 1.3.1.3.5. Actions taken and outcomes achieved as a result of interventions
  - 1.3.1.3.6. Ensuring that provided care is person-centered, i.e., culturally and linguistically appropriate
  - 1.3.1.3.7. Making an appropriate referrals for medical and/or behavioral health services that are not provided within the Health Home
  - 1.3.1.3.8. Appropriate usage use of Electronic Health Records (EHR)

## **2. Provider Infrastructure**

Each Health Home will maintain its multi-disciplinary team in a manner that assures the capacity to provide and arrange for the defined Health Home services. The definition of designated Health Home providers is intentionally broad to allow diverse organizational models to serve as Health Homes.

### **2.1. Health Home Provider Team Structure**

Each health home will define its multidisciplinary team in a manner that assures capacity to provide or arrange for the six defined health homes service. However, at minimum, each team shall include a primary care provider (physician or advanced practice nurse), a licensed behavioral health specialist, a registered nurse, and a care manager (who could be the nurse or the behavioral health specialist for persons with serious mental illness (SMI)). Each team shall include an individual who is designated as a care coordinator but who may also fill other roles. The care manager coordinates the Health Home's team care and is accountable under the medical director for assuring the identification of enrollees' needs and that an effective plan for intervention is developed and carried out.

#### **2.1.1. Required Team Members**

Specific qualifications for the required team member roles are as follows:

- 2.1.1.1. Team Leader: A primary care physician or advanced practice nurse provider
- 2.1.1.2. Behavioral Health Specialist that has a current valid WV license as a Psychologist, Professional Counselor, or a Social Worker
- 2.1.1.3. The Behavioral Health Specialist must have a minimum of a Master's level degree.
- 2.1.1.4. Care Manager: Designated as either a Registered Professional Nurse (RN) or Licensed Certified Social Worker (LCSW)
- 2.1.1.5. The care manager is accountable for assuring the identification of enrollee's needs and that an effective plan for intervention is developed and implemented.
- 2.1.1.6. Care Coordinator: Shall have a Bachelor's Degree in Social Sciences with relevant service, care or counseling experience and works are under the direct supervision of the care manager.
- 2.1.1.7. All team leaders, behavioral health specialists and care managers must be licensed in the state of WV

### 2.1.2. Optional Additional Team Members

Additional Team Members may include but are not limited to the following:

- 2.1.2.1 Pharmacists, social workers, mental health workers, health educators, community health workers, community health workers, lay educators, peer support, etc.
- 2.1.2.2 Specialists, which may include medical sub-specialists such as gastroenterologists, hepatologist, infectious disease team(s), and others dependent upon the enrollee's needs

## 2.2. Provider Agreements and Facilities

### 2.2.1. Provider Agreements

To assure access to appropriate medical and behavioral health services not available directly within the Health Home organization, Health Homes will augment their teams by having Memorandums of Understanding (MOUs) as necessary with providers such as:

- 2.2.1.1. Comprehensive mental health facilities
- 2.2.1.2. Behavioral health facilities
- 2.2.1.3. Medical or behavioral health specialists as necessary
- 2.2.1.4. Hospitals
- 2.2.1.5. Emergency departments
- 2.2.1.6. Long-term care facilities
- 2.2.1.7. Other providers that are part of the respective managed care network in which the Health Home participates
- 2.2.1.8. These relationships, as defined in the MOU, will assure that information across settings is sharable in order to achieve coordinated care for all managed care Health Home enrollees.
- 2.2.1.9. Outside the managed care environment, Health Homes will be expected to define a medical community in which relationships are developed to assure appropriate information sharing and coordination across care settings.
- 2.2.1.10. In addition to the relationships in the above list, the Health Home MOU should include:
  - 2.2.1.10.1. Any National Accreditation achieved by the Health Home, while accreditation is not required at this time; please identify accreditation entities by name in MOUs
- 2.2.1.11. Where a Health Home is not a single business entity, it is required that formal agreements (MOUs) will exist between team members and the Health Home entity that remains responsible for all services performed by the care team.

### 2.2.2. Provider Facilities

Functions and services can be provided in a single location, multiple locations, in person, via telephone or virtually. Use of electronic means of supporting all communications is encouraged.

### 2.2.3. Health Home Required Services

- 2.2.3.1. **Comprehensive Case Management** includes the development, implementation, and ongoing reassessment of a comprehensive individualized patient-centered care plan for each health home member. The care plan's development basis is the information obtained from a comprehensive risk assessment that identifies the member's needs in areas including: medical; mental health; substance abuse/misuse, and social services. The individualized care plan will include integrated

services to meet the member's behavioral health, rehabilitative, long-term care, and social service needs, as indicated.

The care plan will identify the primary care physician, other health and behavioral health care providers, care manager, and other health team providers directly involved in the individual's care. The care plan will also identify community networks and supports needed for comprehensive quality health care. Goals and timeframes for improving the member's health, overall health care status and identified interventions will be included in the care plan, as well as schedules for plan assessment and update.

Comprehensive care management will assure that the member (or legal health representative) is an active team member in the care plan's development, implementation, and assessment and is informed agreement with plan components. Member's family and other recognized supports will be involved in the member's care as requested by the member.

- 2.2.3.2. **Care Coordination** is the delivery of comprehensive, multidisciplinary care to a member that links all involved resources by maintaining and disseminating current, relevant health and care plan data.

Care coordination manages resource linkages, referrals, coordination, and follow-up to plan-identified resources. Activities include, but are not limited to appointment scheduling, conducting referrals and follow-up monitoring, participating in facility discharge processes and communicating with other providers and members/family members.

- 2.2.3.3. **Health Promotion** includes the provision of health education specific to a member's health and behavioral health; development of self-management plans effectively emphasizing the importance of immunizations and preventive screenings; understanding and management of prescribed medications; supporting improvement of social networks; and providing healthy lifestyle interventions. Areas of focus include but are not limited to, substance use and smoking prevention and cessation, nutritional counseling, weight management, and increasing physical activity.

Health promotion services assist members to participate in the development and implementation of their care plan and emphasize person-centered empowerment to facilitate self-management of chronic health conditions through informed awareness.

- 2.2.3.4. **Comprehensive Transitional Care and Follow-up** is care coordination services designed to prevent avoidable emergency department visits, admissions, and readmission after discharge from an inpatient facility.

For each enrollee transferred from one caregiver or site of care to another, the health home team ensures proper and timely follow-up care and safe, coordinated transitions, including reconciliation of medications. Through formal relationships and communication systems with health facilities including emergency departments, hospitals, long-term care facilities, residential/rehabilitation settings, as well as with other providers and community-based services this coordination is accomplished.

- 2.2.3.5. **Patient and Family Support Services** includes service provision and resource identification that assist members to attain their highest level of health and functioning. Peer supports, support groups, and self-care programs can be utilized by providers to increase members' and caregivers'

knowledge about the member's diseases, promote member's engagement and self-management capabilities, while assisting the member to adhere to their care plan.

The primary focus of individual and family supports will strengthen through increased health literacy. This effort will include communicated information that is language, literacy, and culturally appropriate, and designed to improve the member's ability to self-manage their health and participate in the ongoing care planning

- 2.2.3.6. Referral to Community and Social Support Services** includes the identification of available community resources, active management of referrals, access to care, engagement with other community and social supports, coordination of services and follow-up. The member's care plan will include community-based and other social support services that address and respond to the member's needs and preferences, and contribute to achieving the care plan goals.

When necessary the Community and Social Support Services network includes development of policies, procedures and accountabilities (through contractual agreements, where applicable) which clearly define the roles and responsibilities of the participants in order to support effective collaboration between the health home and community-based resources, and the member.

Health Home services are available at two levels. Level One Health Home services require documentation of at least one of the above listed services per member per month. If during a 12-month period a member's need intensifies related to a decompensating of the mental and/or physical condition one unit of level two services may be requested. At level two, Health Home providers to provide services at the intensity and duration needed to stabilize their condition.

#### **2.2.4. Health Home Service Documentation**

Each of the Health Home Services must be documented within the Enrollees Health Home Record. Each service provided must have a service note, which includes

- 2.2.4.1. Enrollee/Member's name
- 2.2.4.2. Name of Health Home Service Provided
- 2.2.4.3. Summary of Service Provision
- 2.2.4.4. Team Member's Signature (legible)
- 2.2.4.5. Team Member's Credentials (legible)
- 2.2.4.6. Date of Service
- 2.2.4.7. Start Time and Duration or Start and End Time of Service Delivery

#### **2.2.5. Other Required Documentation**

- 2.2.5.1. A continuity of care document, an individualized care plan, is required and includes:
  - 2.2.5.1.1. Integrated services that meet the enrollee's behavioral and medical health, as well as rehabilitative, long-term care, and social service needs, as indicated
  - 2.2.5.1.2. Goals and timeframes for improving the enrollee's overall health status with identified interventions and responsible parties
  - 2.2.5.1.3. Schedule of planned assessments and updates
- 2.2.5.2. The continuity of care document will identify:
  - 2.2.5.2.1. Primary care physician/s, other health and behavioral health care providers, care manager, and other health team providers involved in the enrollee's health care
  - 2.2.5.2.2. Community networks and other social supports needed for comprehensive quality health care.

2.2.5.3. An initial and periodic assessment and information review of each enrollee will include, as appropriate, but is not limited to the following:

- 2.2.5.3.1. APS Healthcare Comprehensive CareConnection® (C<sup>3</sup>) for WV Health Homes
- 2.2.5.3.2. CDC Hepatitis Risk Assessment
- 2.2.5.3.3. S-BIRT Assessment
- 2.2.5.3.4. Evaluation of Suicide Risk
- 2.2.5.3.5. Patient Health Questionnaire
- 2.2.5.3.6. Adult Health History Questionnaire
- 2.2.5.3.7. Assist Questionnaire
- 2.2.5.3.8. CIDI-based Bipolar Screening Scale
- 2.2.5.3.9. Functional Screening
- 2.2.5.3.10. Medication Reconciliation
- 2.2.5.3.11. Specific Laboratory Results as appropriate for each individual enrollee
- 2.2.5.3.12. Relevant Biometrics
- 2.2.5.3.13. Treatment History
- 2.2.5.3.14. Written crisis plan for each enrollee

### 2.3. Quality Measures

Please review the Health Home Monitoring, Quality Measurements, and Evaluation section (page 37) of the WV Health Home State Plan Amendment available on the Bureau for Medical Services web site for Health Homes.

## 3. Provider Application to Participate in Health Homes

Health Homes must be an enrolled WV Medicaid Provider and coordinate information sharing with Managed Care Organizations regarding common enrollees.

### 3.1. Application Process

A provider or group may apply to the Bureau for Medical Services for certification as a WV Health Home by submitting a completed Health Home Application available <http://www.dhhr.wv.gov/bms/Pages/default.aspx> and the required narrative.

#### 3.1.1. Provider Certification Reviews

The Bureau for Medical Services or their representative will conduct annual recertification reviews to ensure compliance to State and Federal Regulations. These review audits will include, but not be limited to:

- 3.1.1.1. Verification of the credentials of required team members
- 3.1.1.2. Patient chart review:
  - 3.1.1.2.1. Review of care plans
  - 3.1.1.2.2. Review of disease management
  - 3.1.1.2.3. Review of rendered health home service documentation

### 3.2. Health Home Service Prior Authorization and Payment

**3.2.1. Prior Authorization of Health Home Services:** At the time of each Medicaid Member's initial enrollment in the WV Health Home Program, the assigned, servicing Health Home Provider may obtain prior authorization for Health Home Service using the APS Healthcare Comprehensive CareConnection (C<sup>3</sup>), a web-based, prior authorization system. Note use of C<sup>3</sup> is the only permitted means of submission

of Health Home Service Prior Authorization Requests and associated required data, whereas, alternate means such as hardcopy, faxed, or scanned requests are unaccepted as are telephonic requests.

3.2.1.1. The WV Health Home Program, a two-level service system, is comprised of both a Standard and an Intensive Health Home Service.

3.2.1.1.1. **Level I – Health Home Standard Service (S0281):** This is the standard benefit, intended to cover the provision of the six aforementioned Health Home Services as is required an appropriate to the each member’s needs. Health Home membership includes eligibility for services covered by the Health Home Standard Service.

As the standard benefit, the period of authorization for approved requests is four months (four units of service per four-month authorization). Thus, three times during each twelve-month period, it will be necessary to submit information reflecting each member’s current condition and situation This periodically submitted data will allow the State to meet the CMS Adult Quality Measures, Health Home Program Performance Indicators and other reporting requirements.

3.2.1.1.2. **Level II: Health Home Intensive Service (S0281 TF):** This intensive level of service is available for those members determined to require a greater amount of service than that covered under the standard service one time per calendar year (one unit). It will be necessary for the provider to submit information reflecting each member’s current condition and situation when requesting this Intensive level of service.

**3.2.2. Payment:** With the two levels of service, there are two levels of reimbursement both of which are on a **per member per month** basis for each member. On a monthly basis, providers may receive reimbursement for authorized Standard Services rendered. Additionally, providers may receive remittance for one unit of intensive service once per calendar year in addition to the standard payment.